The consultant contract: marriage or divorce?

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ABSTRACT – At the birth of the new millennium Britain's Labour government published a 10-year plan for modernising the National Health Service (NHS), placing great emphasis on new ways of working. As part of this process, and following extensive negotiation, general practitioners and hospital consultants were offered new contracts in 2003. This process highlighted the issues academic clinicians and managers face in dealing with the tensions inherent in delivering the tripartite mission of teaching, research and clinical service. Following a retrospective review of clinical academic appraisals, this paper considers new strategies for strengthening the relationship across the university and NHS interface and how this novel and strategic approach might be adopted in future health policy. These findings can be helpful for both UK colleagues and for a broader international audience by providing a pragmatic approach to increasing collaboration across the higher education and health service sectors.

KEY WORDS: clinical academic medicine, consultant contract, university and health service collaboration

Academic medicine is in crisis and is in danger of losing its leadership role.[1–3] The root of this problem appears to lie in the challenge of delivering the tripartite mission of clinical service, teaching and research. Unlike Cerberus of Greek mythology, the tripartite mission is not a three-headed monster, but rather an interdependent relationship that underpins a first-class clinical service. Such a service cannot exist without training the doctors and specialists of the future and seeking new pathways of knowledge. Part of the solution to this crisis may be the strengthening of relationships between higher education institutions and their local health service partners. In the UK, the government has embarked on a 10-year programme of modernising the NHS, including the introduction of new contracts for general practitioners and hospital consultants. We believe that this presents a unique opportunity for institutions to work in partnership to deliver the tripartite mission. Excellence in research, learning and teaching underpins a world-class clinical service whether it is developing the future workforce or the translation of basic biomedical research into practice.

Value and pressure of the marriage

Clinical academic staff are employed by universities but their funding may come from diverse sources, including Higher Education Funding Council for England (HEFCE), the NHS, research councils and the medical charities. In many universities, the funding is split between the university and the NHS. Most clinical academics hold a substantive university contract and an honorary NHS contract which requires the two employers to work in partnership. This view was reinforced by the Follett review in 2001.[4] Paradoxically, however, recent policy changes have created an incentive for university and NHS strategies to diverge. The clinical academic is recognised by both parties in the relationship as the pivotal link across this interface.[5] Not only do they deliver the core tripartite mission but they help to inspire in others a culture of enquiry in their practice and provide leadership and specialist clinical services. Furthermore, they play a pivotal role within an increasing knowledge economy, advising on local, national and international committees, where they can influence policy in both government and industry.

Yet despite the rhetoric, the number of unfilled academic posts in the UK remains high,[6] reducing the supply of clinical academics at a time of substantial growth of healthcare professionals to deliver the NHS Plan.[7] This crisis in academic medicine is well recognised, and a recent joint report from the Royal College of Physicians and the Academy of Medical Royal Colleges has provided some sensible solutions to this problem.[8] Much of the attention has focused on training a new generation of clinical academics and making a clinical academic career attractive.[9] Just as important, however, is a commitment to support and retain the current cohort of clinical academics.[10] We believe that the new consultant contract presents a unique opportunity to underpin this objective.

Implementing the contract

At Leeds University, a new Faculty of Medicine and Health has been established, built on a strong

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relationship with the local NHS and our academic track record. The Faculty has a turnover greater than many universities in the UK and it has worked in close partnership with Leeds Teaching Hospitals Trust (one of the largest NHS trusts in the UK) and more recently with Bradford Teaching Hospitals (a foundation NHS trust) in implementing the new consultant contract.

Following extensive local consultation, the Faculty leadership developed a number of key principles to support contract implementation. These were presented to the Leeds Joint Strategic Board for Health, a partnership which brings together the University and local NHS organisations. The key principles to underpin the clinical academic contract were as follows:

- The contract should support the delivery of the tripartite mission of clinical service, teaching and research within the overall spirit of collaboration with NHS service providers.
- The overall portfolio of the clinical academic team will be assessed so that no unilateral decisions are made by either the university or the service provider.
- The contract will recognise effort, commitment, excellence and leadership roles across the tripartite mission.
- Objective measures will be applied to assess academic contribution to teaching and research.
- The contract will be applied in an open and transparent manner.
- The approach will be consistent with that taken by other universities.

The implementation of the new consultant contract for clinical academics is based on a system of joint appraisals, as outlined in the Follett review[4] and rigorous job plans. Appraisal is a professional process of constructive dialogue in which the individual being appraised has an opportunity to reflect on his/her work and consider how his/her effectiveness might be improved. This process enables clinical academic consultants and managers collectively to consider the tension inherent in delivering the tripartite mission and identify both personal and professional needs. Appraisal provides a regular structured system for recording progress and identifying development needs (as part of a personal development plan), which support individual clinical academics in achieving revalidation.

The joint appraisal scheme was used for all clinical academic staff employed by the University of Leeds and who hold honorary NHS contracts at consultant level using standardised methodology[11] and documentation.[12] We carried out a retrospective review of material from 93 clinical academic appraisals undertaken in 2004. The aim was to determine key factors that might strengthen joint collaboration across the academic and health service interface.

The new consultant contract was offered to all 93 clinical academic consultants employed by Leeds University. Of these, 76 negotiated a new contract, which was informed by a rigorous job planning process involving a senior academic and the clinical director for the appropriate speciality. Of the 17 who did not take up the new contract, three have gone through mediation (one is appealing and one of the remaining two has now taken up the contract).

The following common themes emerged from interviews with clinical academics:

- The new contract offers an opportunity to create new clinical academic roles with protected time for research and/or teaching.
- The NHS is a valuable educational and research platform with a great capacity to perform well given an adequate infrastructure.
- Clinical scientific teams have a very important role in the delivery of modern science.
- There are limitations to a Research Assessment Exercise (RAE)-based approach to deliver the potential of NHS-based research.
- Current reward systems are inadequate for those who pursue the full RAE-based academic career.

The new contract for both NHS consultants and clinical academic staff is based on a working week of ten programmed activities (PAs), each of which is equivalent to four hours during which the consultant undertakes contractual obligations. These services may include direct clinical care, supporting professional activities and additional NHS responsibilities for research, teaching, administration and external duties. Additional programmed activities (APAs) represent extra activity that the clinical manager and university may agree with the clinical academic to undertake.

The analysis indicated a greater proportion of clinical academics' activity takes place in the NHS than in the university. This equated to 16% more PAs and 69% more APAs supporting clinical activity rather than academic activity, which reflects the increasing service pressure on clinical academics. Therefore, it is important that academic activity is ring fenced and protected to deliver high quality teaching and ensure that research is internationally competitive.

Whilst academic health partnerships are considered to be strong in Leeds,[13] there are obviously differences between the University and NHS in the philosophy of approach to the implementation of the new contract, where the University inevitably

Key Points

The new consultant contract is placing new pressures on the relationship between universities and the NHS

Clinical academic medicine has not been fully valued with the implementation of this new contract

A number of higher education and NHS collaboration principles and joint strategies have been identified to support the implementation of the new contract for clinical academics

Future policy needs to support greater collaboration and integration across higher education and the NHS effectively to implement the contract

places a stronger emphasis on academic output[14] than the NHS, which tends to concentrate on clinical input (ie time required to deliver health service activity). Recognising and respecting these different perspectives in pursuit of a common goal has been the starting point for our approach to implementation of the new contract for clinical academics in Leeds.

Discussion

The main conclusion of a 'think tank' group from the University and local NHS was that implementation of the contract for clinical academics should be based on the fundamental principle that 'research and lifelong learning should inform a first class clinical service' and that this should be built on a model of clinical governance. The model is the main vehicle for continuous improvement of the quality of patient care through *exploring new forms of collaboration, leadership culture and professional self regulation*,[15] so that research, teaching and clinical quality are integrated at all levels of collaborative working in order to deliver the tripartite mission.

The contract provides a unique opportunity to support the education of future generations of doctors, and help practitioners develop their knowledge, skills and practice to deliver the best evidence-based clinical care.

Although the UK is well positioned to do translational research with the close relationship between teaching hospitals and health faculties, it seems that such research has not always received strong support from research councils and research charities. More worryingly, recent evidence from the Health Development Agency indicates that only 4% of academic and research outputs surveyed were relevant to public health interventions,[16] a finding that requires careful consideration, given the recent White Paper on Public Health, particularly at a time when strategic health authorities and primary care trusts may not regard research as a core activity.

The risk of the new consultant contract being clinically, rather than academically, driven creates tension across the current NHS/university interface, rather than fostering an environment in which the new contract underpins improved performance across academic health systems.

The approach requires flexibility in implementing the contract across the clinical academic team, against the agreed principles, taking into account local conditions and historic patterns of service delivery. We believe that the new consultant contract provides an unparalleled opportunity to develop an integrated model of working, which should facilitate closer collaboration between clinicians, academics and policy makers and help minimise the current inefficient use of resources.

How to build the marriage

We propose three strategies to underpin the collaboration between universities and the NHS to ensure world-class standards of care and the quality of teaching and research:

1 Establishing new integrative approaches and *new organisational models of clinical academic collaboration.*
2 Creating new dimensions of *leadership and teamwork*, where the new partnership culture promotes and reinforces excellence, and is based on a system of reward and parity of funding.
3 Emphasising that local professional self-regulation and peer review is important in dealing with complex problems of poor performance for clinical academics, which requires at the outset a robust *joint performance measurement system.*

First, *new organisational models of clinical academic collaboration* need to be considered. As a member of the Association of Academic Centers of North America, the Leeds University Faculty of Medicine and Health has been exploring how to establish an integrated approach to deliver the tripartite mission as a clinical academic centre, recognising that there is 'no one model that fits all'. We have identified and implemented three models fitting regional and national contexts:

- research-led institutes of critical mass and international competitiveness
- clinical disease-based academic centres
- institutes functioning in joint governance across the NHS/university interface.

Second, *leadership and teamwork* are the essential components of successful clinical academic teams. The cycle of decline of academic medicine does not stem from a single factor, but reflects a strong view that academic clinical medicine is not valued in these turbulent times. Whether it is an absence of input to national strategy or the cyclical cull of staff prior to each research assessment exercise, the climate in which clinical academics are working would indicate that the case for strong academic leadership and professional management has never been greater.

A critical component of clinical academic leaders is not only their ability to lead, but also their role in developing others[17] who can manage and lead. The new consultant contract requires individuals and teams to display competence and credibility in leadership,[18] recognising that leadership is required at all levels of the organisation and that success is dependent on facilitating leadership in others.

In clinical academic medicine, individuals need to be part of an adequately sized team providing a clinical service. Such an arrangement allows protected time for teaching and research whilst enabling clinical commitments to be balanced within the team. If health professions work in teams they must learn in teams and it is therefore important that, as the contract develops over time, a reward system is developed based on new approaches to education and research.

The contractual arrangements for clinical academics have historically been vague and have generally been without clear expectation or linked to reward. Working in integrated teams will require parity in recognition of both university and NHS staff. Remuneration has been a major threat to academic medicine in the USA and the UK,[19] due to earnings lost in training and to reduced earnings in private practice. The initial delay in releasing funding for clinical academics and the absence of retrospective funding for APAs has further undermined the role

and perceived 'value' of clinical academics in comparison to their NHS consultant colleagues. The arrangements are further weakened for new medical schools, which will not receive funding for APAs beyond the 2004/05 baseline, recognising that an ultimate goal for all job plans is to have a ceiling of 10 PAs. It is clear that greater weight should be given to the contribution academics make to the NHS in terms of teaching and research into better clinical care.[20]

Third, it is clear that a *joint performance measurement system* is required to support the implementation of the contract, and we have established a minimum dataset of performance indicators of both individuals and teams,[21] which can measure the outcomes of their work in a meaningful and manageable way. The dataset incorporates contribution to key clinical targets, research outputs[22] and teaching activities.[23] The arrangements are underpinned by the principles set out in the Follett review, which recognises that clinical academics tend to incline towards teaching and research and are rarely able to deliver all components of the tripartite mission at an international level.[4]

Future of the contract

Clinical academics play a significant role in hospitals and the wider NHS and are judged increasingly by public authorities and by the public. The contract for clinical academics currently sits across one of the most complex groups of organisations in our society,[24] which has a common purpose in improving the health of the population.

The new contract places new pressure on the relationship between universities and the NHS, which can be reduced by adopting stated principles of contract implementation and pursuing a clear strategy. We hope that these findings will be helpful not only for our colleagues and policy development in the UK but for a broader international audience by providing a pragmatic approach to increasing collaboration across the higher education and health service sectors.

The contract enables us to build a shared sense of purpose across academic health systems through strong leadership, exchanging and creating information and developing new models of working. The temptation to manage the separate components of the tripartite mission within the contract only serves to fragment the marriage and ultimately reduce competitiveness across both sectors. We would urge both sectors to consider how future policy enhances the marriage, against recent experience, which has tended to create grounds for divorce.

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